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MEDICAL SERVICES

MEDICAL SERVICES

M1800 MEDICAL SERVICES

M1810.100 MEDICAID ELIGIBILITY CARD

A. Medicaid Card Issuance

A Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). A new card is issued each month as long as the recipient remains eligible. Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

Exception: The following recipients do not receive a monthly Medicaid card:

- individuals eligible for Medicare premium payment only,
- individuals in a nursing facility, and
- recipients enrolled in a Medallion II Managed Care Organization (MCO).

B. Use of the Medicaid Card

1. General

Local social services departments must provide recipients with information concerning use of the Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,
- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
- knowingly permitting another person to use an individual's card to secure medical care.

The recipient must be advised that it is his responsibility to return his Medicaid card to the local social services department when he is no longer eligible for Medicaid.

2. Foster Care Children in Institutional Facilities

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in a child caring institution or admitted to an institution for the mentally retarded. Upon receipt of the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

3. Nursing Facility Patients

Patients in long-term nursing facilities do not receive Medicaid cards. The nursing facility receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility. Each patient's name, Medicaid number, and medical resources code is included on this listing.

This listing reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet" to Medicaid, and whom Medicaid has entered on its Long-Term Care Information computer subsystem. Therefore, the patient will receive a Medicaid card until DMAS enters the patient information into the subsystem and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. If the facility fails to notify the LDSS when a patient is discharged to the community, the patient will not receive a Medicaid card until the LDSS is notified of the discharge. Long-term care providers have been instructed to notify the LDSS of death or discharge via the DMAS-122.

M1820.100 SERVICE PROVIDERS

A. Enrollment Requirement

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services from DMAS and are available online at www.dmas.state.va.us.

B. Out-of-State Providers

1. Covered Services

Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

a. the general custom of the eligible individual (e.g., a recipient living near the border of another state),

b. needed by a non IV-E Foster Care child placed outside Virginia,

c. necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or

d. indicated because of referral to an out-of-state facility when preauthorized by DMAS.

2. Provider Enrollment

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

M1830.100 MANAGED CARE

A. General Information

Most Virginia Medicaid recipients are required to receive medical care through a managed care program. There are two managed care programs that operate simultaneously within the Commonwealth: The MEDALLION Program, a Primary Care Case Management program, and Medallion II, a program that requires mandatory enrollment into a contracted Managed Care Organization (MCO) for certain groups of Medicaid recipients. Both programs require recipients to choose a primary care provider (PCP) who provides primary health care services and makes referrals as needed. Enrollment in managed care is based on information provided by the eligibility worker to the Medicaid Management Information System (MMIS) during Medicaid enrollment.

B. Recipients Exempt from Managed Care

General

The following recipients are not required to enroll in a managed care program and may seek medical care from any provider enrolled by DMAS as eligible to receive payment:

- children in Foster Care (including Treatment Foster Care), Adoption Assistance, and Residential Treatment Facility programs;
- inpatients in State mental hospitals, including but not limited to:
  - Central State Hospital,
  - Eastern State Hospital,
  - Western State Hospital,
  - Hiram W. Davis Medical Center,
  - Northern Virginia Mental Health Institute,
  - Southern Virginia Mental Health Institute,
  - Southwestern Virginia Mental Health Institute, and
  - The Commonwealth Center for Children and Adolescents (formerly known as the DeJarnette Center).
- inpatients in long-stay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR), and recipients approved for Medicaid community-based care waiver services;

- Qualified Medicare Beneficiaries (QMB), dually-eligible recipients, Special Low-income Medicare Beneficiaries (SLMB), Qualified Individuals, and Qualified Disabled and Working Individuals (QDWI);

- recipients with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program;

- recipients enrolled in the Aged, Blind or Disabled (ABD) with Income $\leq$ 80 % Federal Poverty Level (FPL) covered group;

- women enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group;

- women enrolled in the Family Planning Services (FPS) covered group;

- recipients who receive hospice services in accordance with DMAS criteria;

- refugees; and

- recipients on a spenddown.

MEDALLION

The following recipients are excluded from participating in MEDALLION:

- recipients who are not accepted to the caseload of any participating PCP, and

- recipients whose enrollment in the caseload of the assigned PCP has been terminated and whose enrollment has been declined by other PCPs.

Medallion II

The following recipients are excluded from participating in Medallion II:

- recipients, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those placed there for medically necessary services funded by the MCO;

- newly eligible Medallion II enrollees who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their MCO enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. The enrollee, MCO, or obstetrical provider can make exclusion requests. Following end of pregnancy, these individuals shall be required to enroll in Medallion II to the extent they remain eligible for full Medicaid benefits.

- recipients who have been pre-assigned to the MCO but have not yet been enrolled, who have been diagnosed with a terminal condition, and whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.

- recipients who are inpatients in hospitals, other than those listed above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge.

- Certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) and who meet DMAS review.

1. Foster Care/ Adoption Assistance Children

All Foster Care and Adoption Assistance children enrolled in MMIS with a Program Designation (PD) of 74, 76, or 86 are automatically excluded from participating in managed care. Foster Care/Adoption Assistance children who are enrolled under any other PD can be exempted from Medicaid managed care programs. If a worker finds that a Foster Care/Adoption Assistance child is enrolled in a managed care program, the worker may request that the child be removed from managed care and placed in fee-for-service Medicaid through the following process:

- Complete the Foster Care Child-Exemption from Managed Care form (see Appendix 1 to this chapter). The custody order, *emergency removal order, or a statement on agency letterhead signed by the director or foster care supervisor verifying the child is in the agency's custody and the date the agency received custody* must be attached to the form in *order to have the child exempted from managed care.*

- Fax the form to *(804) 786-5799.*

Exemption requests may take up to 5 business days to complete. Disenrollment is effective at the end of the month of notification (not retroactively. The LDSS can verify disenrollments by *checking the MMIS Managed Care Assignment screen for a managed care end date.*

2. Other Exempt Recipients

Recipients other than Foster Care/Adoption Assistance children not enrolled in PD 74, 76, or 86 who are exempt from enrollment in managed care are excluded based on information supplied to MMIS at the time of enrollment.

C. Choice of Managed Care Programs/PCPs

Recipients who are required to participate in a managed care program will be notified within 15 - 45 days of enrollment in Medicaid and asked to choose either a MEDALLION PCP or one of the Medallion II MCOs operating in the recipient's geographical region. A list of MCOs operating in each region can be obtained online at www.dmas.state.va.us or by contacting the Managed Care Helpline at 1-800-643-2273 to request a comparison chart.

D. Good Cause

MEDALLION

The MEDALLION program has an annual open enrollment period of 90 days that applies to individuals in MEDALLION only areas. During the open enrollment period, MEDALLION enrollees may change Primary Care Physicians (PCPs). If an enrollee wishes to change his PCP outside of the open enrollment period, he must make a good cause request to DMAS.

Medallion II

In the Medallion II program, good cause consists of a pre-defined set of operational conditions that allows an enrollee to change from one Managed Care Organization (MCO) to another. In areas where there is only one MCO, an enrollee may change from either MEDALLION or the MCO to the other program. The good cause provision applies only after the initial 90-day enrollment period has ended.

If a good cause reason exists, the enrollee must write a letter to the DMAS Managed Care Division providing supporting documentation. All written correspondence should be directed to the following address and/or fax number:

The Department of Medical Assistance Services
Managed Care Division
600 East Broad Street
11th Floor
Richmond, VA 23219
(fax) 804-786-5799

DMAS will review all good cause requests. Only the following reasons, if applicable, will result in approval:

- quality of care,
- access issues,
- receipt of care at a Rural Health Clinic or Federally Qualified Health Center that is not enrolled with the current MCO as a participating provider, and
- extreme medical conditions.

E. Enrollment Corrections/ Changes

DMAS pays a capitation rate for every month a recipient is enrolled in managed care regardless of whether the recipient receives medical services during the month. If a recipient is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

F. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are different than the benefits that children enrolled in MEDALLION, Medallion II, and Medicaid fee-for-service receive. The FAMIS benefit package is modeled after the Key Advantage benefit package available to state employees. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance.

The FAMIS benefit delivery system is available throughout the Commonwealth through either MCOs or FAMIS fee-for-service. In most of Virginia, children are enrolled with a contracted managed care organization. Whenever possible, DMAS offers FAMIS families a choice when receiving their health care. In most areas, enrollees may choose from at least two MCOs. In a few localities, however, there is currently only one MCO available to FAMIS enrollees. Children in these areas will be covered by the available MCO. They may not request an MCO change and are not eligible for the MEDALLION Program.

In a few areas of Virginia where there are no MCOs, children enrolled in FAMIS receive benefits through FAMIS fee-for-service. They have no co-payments and their benefits are similar to Medicaid. Refer to the FAMIS website at www.FAMIS.org for more information.

M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Long Term Care and Quality Assurance Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

Recipients in long-term care are reviewed at least once every six months to determine the continued need for long-term care. Their treatment and level of functioning is compared to the Medicaid long-term care regulations for nursing care. If a recipient no longer meets the regulations for long-term care, DMAS notifies the provider and the recipient at least 10 days in advance that Medicaid payment for the care will stop. The recipient has the right to appeal this decision. Long-term care providers have been instructed to notify the LDSS of discharge via the DMAS-122.

B. Client Medical Management Program

Recipients' utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by the Department of Medical Assistance Services. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the Client Medical Management Program and required to select a primary physician and/or pharmacy or both.

Recipients identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to the Department of Medical Assistance Services. The local agency service worker will be asked to interview the recipient and gather information for DMAS. Following receipt of that information by the Department of Medical Assistance Services, the recipient's Medicaid card will have the names and provider numbers of the selected physician and pharmacy on it. Recipients who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the Client Medicaid Management Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services. Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Recipients who have problems with bills or services from providers of care should be referred as follows:

Fee-for-Service Medicaid Recipients

Fee-for-service Medicaid recipients should be referred to the DMAS Recipient Helpline at 804-786-6145. Recipients who need assistance with transportation should be referred to the DMAS transportation broker at *866*-386-8331.

Recipients Enrolled in Managed Care

Recipients enrolled in managed care should be referred to the Managed Care Helpline at 800-643-2273. Medallion II enrollees may also contact their MCO directly. MEDALLION enrollees who need assistance with transportation should be referred to the DMAS transportation broker at *866*-386-8331. Medallion II enrollees who need assistance with transportation must contact their MCO directly.

B. Copayments

Most Medicaid covered services have a “copayment,” which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from $1.00 to $3.00 for most services. There is a $100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the recipient at the time the service is provided.

B. Individuals Exempt from Copayments

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,
- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and
- individuals receiving Medicaid community-based care (CBC) waiver services and hospice care.

C. Services with No Copayments

The following services do not have copayments:

- emergency-room services,
- pregnancy-related services,
- family planning services, and
- dialysis services.

D. Covered Services

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- clinical psychologist services;
- community mental retardation services, including day health rehabilitation services and case management;
- dental services for individuals under age 21 years;
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services, including personal care, adult day health care, respite care, private duty nursing, case management, mental retardation services, and services for the developmentally disabled;
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;
- hospice services;

- inpatient hospital services;
- intermediate care facility-mental retardation (ICF-MR) services;
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);
- mental health services, including clinic services, case management, psychosocial rehabilitation, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services;
- nurse-midwife services;
- nursing facility care;
- optometrist services;
- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;
- outpatient hospital services;
- physical therapy and related services;
- physician services;
- podiatrist services;
- prescribed drugs;
- prosthetic devices;
- Rural Health Clinic services;
- skilled nursing facility services for individuals under age 21 years;
- transplant services; and
- transportation to receive medical services.

Explanations of some covered services are provided below:

1. Clinic Services

Covered clinic services include therapeutic, rehabilitative, or palliative items or services, and renal dialysis furnished to an outpatient by or under the direction of a physician, in a certified facility which is organized and operated to provide medical care to outpatients.

2. Community-Based-Care Waiver Services

Virginia provides services under community-based care (CBC) waivers to specifically targeted individuals. These services are not available to all Medicaid recipients. The CBC waivers are:

- Acquired Immundeficiency Syndrome (AIDS) Waiver,
- Elderly and Disabled (E&D) Waiver,
- Consumer-directed Personal Attendant Services (CD-PAS) Waiver,
- Mental Retardation (MR) Waiver,
- Technology Assisted Waiver, and
- Individual and Family Developmental Disabilities (DD) Support Waiver

Services covered under the waivers are listed in M1410.040.

3. Community Mental Health and Mental Retardation Services

Certain mental health and mental retardation services are covered for Medicaid-eligible recipients when provided by Medicaid-enrolled mental health providers.

Examples of community mental health services are mental health case management, psychosocial rehabilitation, mental health support, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services.

Mental retardation case management is available to recipients who are not enrolled in the Mental Retardation (MR) Waiver. Other community mental retardation services are available to recipients enrolled in the MR Waiver and include mental retardation case management, day support, residential support, and supported employment services.

4. Dental Services

a. Smiles for Children Program

*Beginning July 1, 2005, all Medicaid and FAMIS covered dental services are provided under the "**Smiles For Children**" program, administered by Doral Dental USA. The managed care organizations (MCOs) no longer provide dental services to Medicaid and FAMIS recipients who are enrolled in an MCO. All recipients use their Commonwealth of Virginia Department of Medical Assistance Services or MCO-issued ID card to receive dental services. Coverage for medical services is not impacted by this change.*

*The toll-free telephone number for the **Smiles For Children** member services is 888-912-3456 (Monday through Friday from 8:00 a.m. to 6:00 p.m.). Recipients can obtain provider lists, appointment assistance, member handbooks, and information about dental services and claims.*

b. *Covered Dental Services* For Recipients Under Age 21

Covered services include services for relief of pain and elimination of infection, preventative services such as oral prophylaxia and flouride treatment, routine therapeutic services for the restoration of carious teeth, and diagnostic services.

Procedures such as orthodontics, dentures, braces, partial and permanent bridge work must be preauthorized by *Smiles for Children*.

c. *Covered Dental Services* For Recipients Over Age 21

Covered services include limited oral surgery services when performed by a participating dentist and when generally covered under Medicare and/or are medically necessary. Examples of covered services include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses.

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.

5. Early *and* Periodic Screening, Diagnostic and Treatment (EPSDT) Services

a. General

1. Health screening services are provided to all eligible individuals under age 21 including those who are married or emancipated. The local agency must inform eligible individuals of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program; however, participation is voluntary. Screening services and treatment may be provided by local health departments and private practitioners.

2. Medicaid must cover any medical service identified as medically necessary by an EPSDT screening. When the identified service is not a Medicaid-covered service, DMAS must pre-authorize payment for the service. The service provider and the EPSDT screener are responsible for obtaining this pre-authorization.

3. Some examples of non Medicaid-covered medical services that must be covered by Medicaid under EPSDT are inpatient psychiatric hospitalization, chiropractic care, and specific therapies such as speech and language therapy.

b. Types of Screening

1. Initial physical examinations to screen all children committed to the care and custody of *an LDSS* to ascertain any physical or mental defects and other health needs of each child are covered.

2. Usually, not more than one screening examination per 12-month period is covered for each foster care child between the ages of 3 and 21 years.

3. Children from birth to age 3 may be covered for screening at more frequent intervals. Immunizations given during visits for screening examinations will be covered for foster care children.

4. Procedures for the EPSDT screening of children are specified in the Social Services Manual, Volume VII.

6. Family Planning Services

Covered family planning services are those family planning drugs, supplies, and devices provided under the supervision of a physician. They do not include any services to promote or restore fertility or sexual function.

7. Home Health Services

Covered home health services include all services provided by an authorized home health agency under a plan of treatment prescribed by a physician.

8. Hospice Services

Care in a Medicaid-certified and enrolled hospice is covered for terminally-ill Medicaid recipients. DMAS must pre-authorize the payment for eligible recipients.

9. Inpatient Hospital Services

a. Inpatient hospital stays for recipients age 21 and over must be preauthorized by DMAS. Emergency admissions must be authorized within 24 hours of admission.

Inpatient hospital stays for children under age 21 years must be medically necessary and preauthorized by the DMAS.

b. Inpatient psychiatric hospital stays are covered only for recipients over age 65 years, and for children under age 21 if identified as necessary by EPSDT screening or exam and pre-authorized by DMAS.

10. Laboratory and X-Ray Services

Laboratory and x-ray services are covered when ordered by a physician and may be provided in a physician's office, certified independent laboratory, State Health Department laboratory, or local health department.

11. Medical Supplies and Equipment

Medicaid will cover blood glucose self-monitoring test strips for children under the age of 21 with diabetes and pregnant women with gestational diabetes. Medicaid will cover blood glucose self-monitoring test strips for individuals over the age of 21 who are eligible for durable medical equipment, when certain criteria are met.

Medicaid will cover prosthetic devices (artificial arms, legs, and supportive devices) when prescribed by the physician, preauthorized by the Department of Medical Assistance Services, and furnished by a qualified participating provider.

Respiratory equipment and oxygen supplies are covered.

Ostomy supplies are covered.

Other medical supplies and equipment are covered only for patients receiving renal dialysis or home health care services, and for children under age 21 when the need for the supply or equipment is identified as medically necessary through an EPSDT screening or exam. Medicaid will cover the balance of charges for supplies and equipment covered by Medicare when Medicare has made partial payment on the supplies and/or equipment.

12. Nurse-Midwife Services

Services are covered when provided by a licensed Medicaid-enrolled nurse-midwife, as allowed under Virginia law.

13. Nursing Facility Care

a. Nursing facility services are covered when provided in medical institutions licensed as nursing facilities by the State Health Department and certified by DMAS.

b. Nursing care in intermediate care facilities for the mentally retarded (ICF/MR) is not a covered service for recipients enrolled as MN.

14. Optometrist Services

Eye examinations that licensed optometrists and opticians are legally authorized to provide are covered. A routine, comprehensive eye examination is allowed once every 24 months. Preauthorization is not required. Eyeglasses (lenses and frames) are covered for children under age 21 years. Preauthorization for eyeglasses is not required.

15. Outpatient Hospital Services

Outpatient hospital services are covered when furnished by or under the direction of a physician or a doctor of dental surgery. Diagnostic services are covered only when ordered by a physician.

16. Physical, Occupational and Speech Therapy

Therapy services are covered only as an element of hospital care (inpatient or outpatient), nursing facility care, or home health care, or if prescribed by a physician and provided by a Medicaid-enrolled therapy provider.

17. Physician Services

Services are covered when provided by physicians licensed to practice medicine, osteopathy, and psychiatry.

18. Podiatrist Services

Medicaid payment is limited to medically necessary diagnostic, medical, or surgical treatment of the foot. Routine and preventive foot care is not covered.

19. Prescribed Drugs

Services are limited to generic legend drugs except when the physician specifies "brand necessary" name drugs. When prescribed by a physician, insulin, insulin syringes and needles, and family planning drugs and supplies are covered.

20. Rehabilitation Services

Preauthorization requirement

All rehabilitative services must be pre-authorized by DMAS.

Intensive Inpatient Rehabilitation

Medicaid covers intensive inpatient rehabilitation services provided in facilities certified as rehabilitation hospitals or in rehabilitation units in acute care hospitals, which are certified by the Department of Health as excluded from the Medicare prospective payment system.

Intensive Outpatient Rehabilitation

Intensive outpatient rehabilitation services provided by facilities certified as comprehensive rehabilitation facilities (CORFs), or by an outpatient program administered by a rehabilitation hospital or exempted rehabilitation unit of an acute care hospital, which are certified and participating in Medicaid are covered.

21. Transplant Services

Transplant services are covered as follows:

- kidney, cornea, heart, lung, liver without age limits;
- liver, heart, lung, small bowel, bone marrow, and any other medically necessary transplant procedures that are not experimental or investigational for recipients under age 21; and
- bone marrow transplants for individuals over age 21 for a diagnosis of lymphoma, breast cancer, leukemia, or myeloma.

DMAS must preauthorize all transplants except corneal transplants.

22. Transportation to Receive Medical Services

Non-emergency transportation to a medical service is covered only when preauthorized by the DMAS transportation broker. *The toll-free telephone number for the transportation broker is 866-386-8331.*

Transportation is only covered when the recipient is being transported for the purpose of receiving or returning home from a Medicaid-covered service.

E. Babycare Services

Medicaid has a program of expanded services for all Medicaid-eligible pregnant women and high risk infants under age 2 years. The package of services is called Babycare. Physician, hospital, clinic, and nurse-midwife services are covered, as described above. Risk-assessment, nutrition counseling, patient education, homemaker services, and substance abuse residential and day-treatment services are also covered when prescribed by the physician.

Women and infants who are determined by the physician to be at high-risk for birth-related complications, as defined by DMAS, are eligible for maternity care coordination services, when referred by the physician, in addition to the other Babycare services. The maternity care coordinator is a case manager (usually a nurse or social worker) who develops a plan of care for the pregnant woman or the infant, ensures that the recipient has access to necessary services, provides counseling, and assures that the recipient keeps medical services appointments.

DMAS prints a Babycare pamphlet which is available to local social services agencies and must be ordered from DMAS. It is available in several languages. Recipients may also call the Babycare toll-free Helpline at 1-800-421-7376 between 10:00 a.m. and 3:30 p.m., Monday through Friday, to receive information about Babycare services.

F. Medical Coverage for Specified Aliens

Medicaid covers emergency services for unqualified aliens and qualified aliens eligible for emergency medical services only who meet all other Medicaid eligibility requirements when these services are provided in a hospital emergency room or inpatient hospital setting. DMAS determines both whether services are considered emergency services and the period of coverage.

M1860.100 SERVICES RECEIVED OUTSIDE VIRGINIA

A. General

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Preauthorization Requirement

Virginia Medicaid will cover a recipient who is placed in a long-term care facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

Foster Care Children

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.

FOSTER CARE CHILD
EXEMPTION FROM MEDICAID MANAGED CARE PROGRAMS
(MEDALLION and Medallion II)

A copy of the Custody Order or Removal Order must be attached to this form in order for the disenrollment to be processed. In the event the Custody Order or Removal Order is not available, a statement on agency letterhead signed by the director or a foster care supervisor verifying the child is in the custody of the agency and the date the agency received custody must be included with this form.

In order for exemptions to occur in a timely manner, please fax this form to Tabitha Taylor at 1-804-786-5799.

Medicaid Enrollee ID#_____ Name_____

Address_____ Date _____

_____ City/County Code _____

_____ Case Worker _____

Medicaid Enrollee ID#_____ Name_____

Address_____ Date _____

_____ City/County Code _____

_____ Case Worker _____

Disenrollment is not retroactive. Disenrollment can be confirmed by checking the VaMMIS Managed Care Assignment screen for a managed care end date.